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International Organizations, Health, and Nation Building in Nicaragua

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Recent studies have critically analyzed the theory and practice of the World Health Organization (WHO) and other international health organizations in the planning and execution of primary health care programs in the Third World. Navarro (1984) argues that the Alma Ata Declaration sees primary health care more in terms of accessible health services. While not minimizing the importance of an expansion of medical services, Navarro notes that "most improvements in health have been due to changes in economic, social and political structures rather than in the health sector" (1984:472). Heggenhougen (1984) suggests that calls by WHO for community participation will not by themselves alter the power relations in a state. In fact, community organizing may lead to state repression. Ugalde (1985) argues that the embrace of community participation within WHO-sponsored programs may in fact legitimize low-quality care for the poor while generating their support for regimes for whom equity, in fact, is not on the political agenda. More recently, Donahue (1986) and Green (n.d.) note that, once organized for health, communities can make demands that governments might not otherwise have anticipated or wanted. In that regard, Rifkin and Walt (1986) have observed that international health organizations have turned of late to the promotion of top-down, "categorical" health programs rather than continue with broad-based, comprehensive health programs that are more politically sensitive.

The purpose of this discussion is to address primary health care and international assistance within the context of Nicaragua's unique history and evolving political economy. Given the fact that international health organizations are involved in programs of primary health care in all countries of Central America, including Nicaragua, the discussion will, one hopes, provide for more of a comparative perspective on the politics of international assistance than might result either from a one-country study or from an analysis of the policy statements of the international agencies themselves.

Context

The Nicaraguan political economy has passed through three periods since the revolution of 1979, each of which has had a different impact on the health sector. During the First Period (1979-1984) there was an enormous effort made to reconstruct a country left devastated by the Somoza dictatorship and nearly two years of civil war. The major reforms included the confiscation of the Somoza family land holdings, economic nationalization and the widening of foreign trade, public investment in the domestic economy, agrarian reform, a mixed economy, and political decentralization combined with popular participation. Changes in the health sector during this period of rapid transformation included the creation of a nationalized health system that integrated twenty-three semiautonomous health bureaucracies that had duplicated and fragmented health services before the revolution (Bossert 1982, 1985; Donahue 1986; Williams 1983).

To further guarantee that all would have access to the health system, the Ministry of Health (MINSA) developed a territorial structure in which the entire country was divided into six regional health administration units, three special health zones, and a total of 103 health areas each served by a clinic or health post (see map). Medical school enrollments were dramatically increased, and, with the Law of Obligatory Social Service, previously underserved areas of the country began to receive medical personnel (tables 1 and 2).[1] During this period, health became the engine of popular participation in extensive education programs coordinated with mass drug administration efforts (Popular Health Days), and carried out through the newly created Popular Health Councils. The MINSA began to develop its planning capacity during this time, but in the process found itself in a struggle between two primary health care strategies, one that emphasized a clinical or institutional approach and another that stressed "outreach," prevention, and nonclinical medicine (Donahue 1986). Associated with each approach was the training of community health workers and midwives who would work in coordination with area clinics and popular health councils (Scholl 1985).

During this "Golden Age" of health care the incidence of communicable diseases declined, polio was eliminated in 1982, and a massive anti-malaria campaign reached

70.1 percent of the population (Garfield and Vermund 1983; tables 3 and 4). The World Health Organization declared Nicaragua to be a model for countries seeking to meet the goal of "Health for All by the Year 2000."

Health Planning in War Time

During the Second Period (1984-1985), the political economy evidenced the growing impact, economic and military, of the contra war. The war resulted in the loss of both human and material health resources (Garfield 1985; Garfield et al. 1987; Williams 1987). UNICEF estimates that 348 health technicians and professionals, of whom 48 were employees of the MINSA, were killed in the conflicts between 1980 and 1987 (CARE 1988:6). Losses of social service facilities include 67 schools and 125 social service and feeding centers. The loss of health infrastructure must be counted not only in terms of actual material destruction, but also in terms of lost services that would have otherwise been provided during the past eight years (see tables 1 and 2). The Ministry of Health reported that by the end of 1987, 106 of the 600 health units in the country were closed because of the war. According to the CARE report, these included the partial or complete destruction of 1 hospital, 7 health centers, and 61 health posts (CARE 1988:36). Another 37 health posts were closed and construction on another 22 was abandoned due to contra raids (CARE 1988:6).

Mancotal is a government resettlement and agricultural cooperative some three hours north of the municipal seat of Jinotega. Most of the 120 families come from the Pantasma Valley, a scene of constant fighting farther to the north along the Honduran border. The community health center was first attacked and destroyed in 1983 and has subsequently been rebuilt and destroyed two more times. Contras, who reportedly consider it a "sin" to live in the settlements, come into the town at night and selectively attack the homes of those who are more involved in social and economic development. Residents no longer farm cooperatively and must now travel three hours to Jinotega for health services. The CARE team concluded, "It is difficult to determine what motivates these people to stay in a very dangerous area . . . Were a permanent cease fire to come, they uniformly stated that their goals would be to recondition the health center, recruit a medical staff, and to grow more food" (CARE 1988:60).

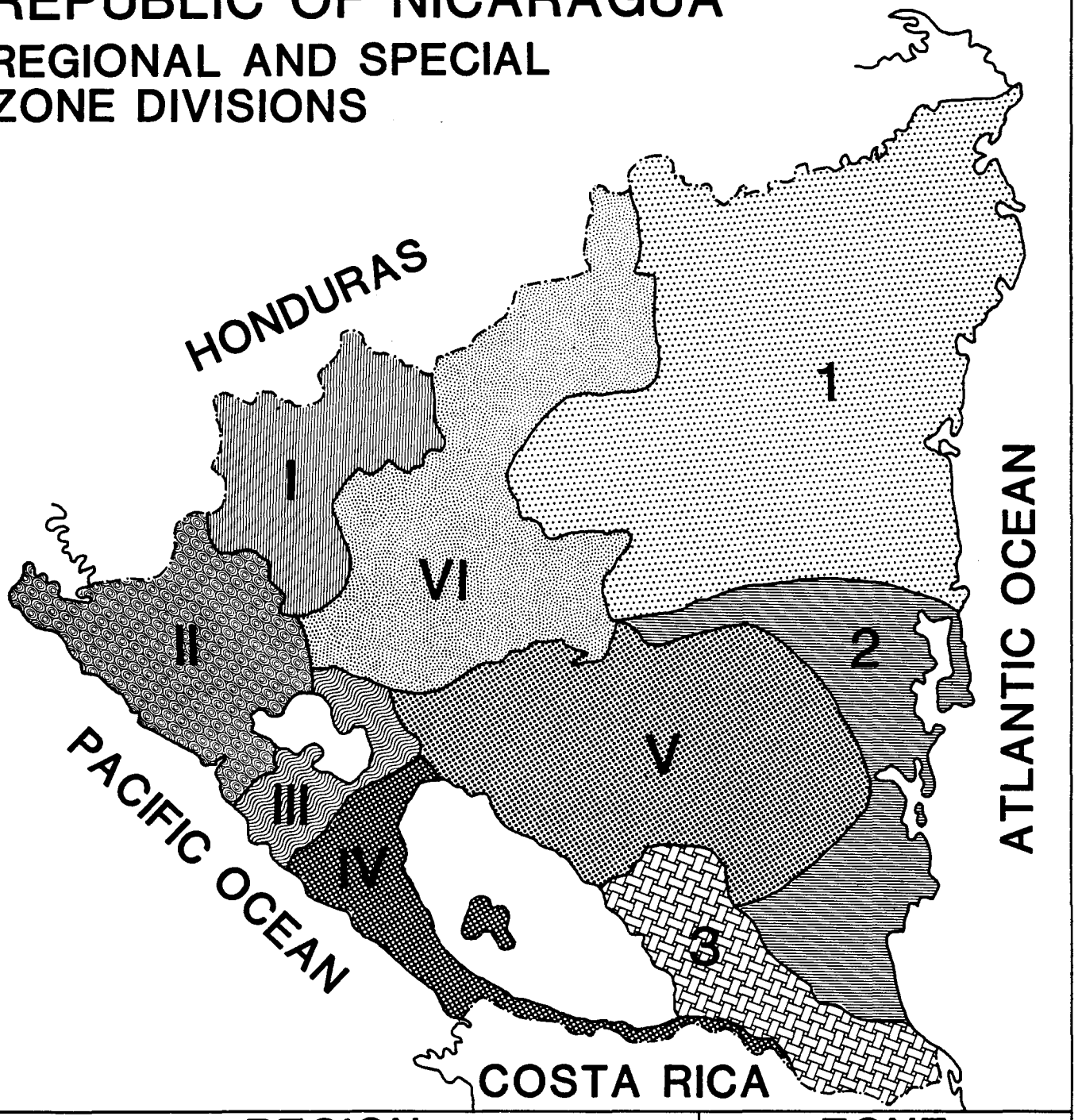
The Ministry of Health (MINSA) responded to the escalating costs of the war by shifting resources to meet the medical needs of soldiers and civilians, especially casualties requiring specialty care and rural peoples displaced by the war.

The original model of the National Unified Health System (SNUS) changed under increasing economic and military pressure. There was a shift to the training of medical specialists whose services demanded greater investments in hospitals and medical equipment. Health ceased to be the cutting edge of popular participation. Primary health care was no longer a priority and patients began to seek medical attention in already crowded hospitals, bypassing, in many instances, the area clinic. During this period, many of the advances made between 1979 and 1984 showed signs of reversal. Vaccinations leveled off in 1984 and 1985 (table 3), and cases of measles and whooping cough rose, especially in the war-torn, central region of the country (table 4). Health personnel had fewer supplies and medicines, were frequently rotated, and were not able to do more than try to keep up with clinical demand. Summing up the situation, CARE observed that "the public health budget in Nicaragua through 1983 had increased the share for primary health care and reduced the proportion for hospital care. Since 1984, hospital care has again received relatively greater funding. The war led to a step backward in the health system, toward greater dependence on specialty skills of surgeons and physicians and a subsequent decline in attention to preventive health measures" (CARE 1988:41).

During the Third Period (1986-1988), the political economy witnessed efforts "to guarantee to the people . . . the basic necessities for survival, adapting strategies of an economy of resistance, having as its fundamental objective assurance of the defense and the economic future of the country" (MINSA 1988a:5). First, several organizational steps were taken to correct previous imbalances in the delivery system. There was a reorganization in the health sector in an effort to restore the planning function, to revitalize prevention programs, and reinstate the referral system. To address a lack of correspondence between health policies and priorities and the actual workings of the system at the regional or area level, more flexibility was sought to allow the various regions to adapt to local needs especially in the areas of prevention and health education. More coordination with health efforts of the military services and the private sector was also made a priority.

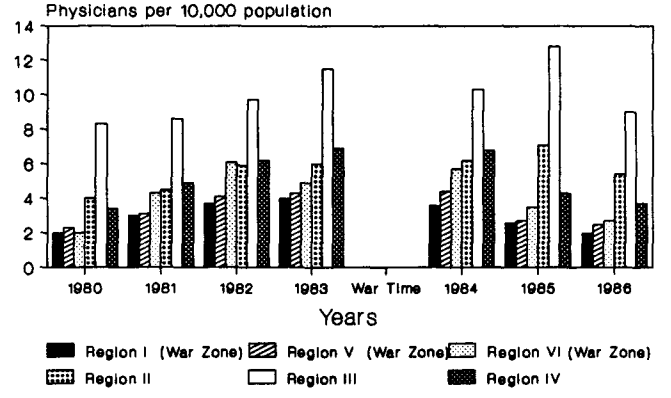
REPUBLIC OF NICARAGUA

REGIONAL AND SPECIAL ZONE DIVISIONS



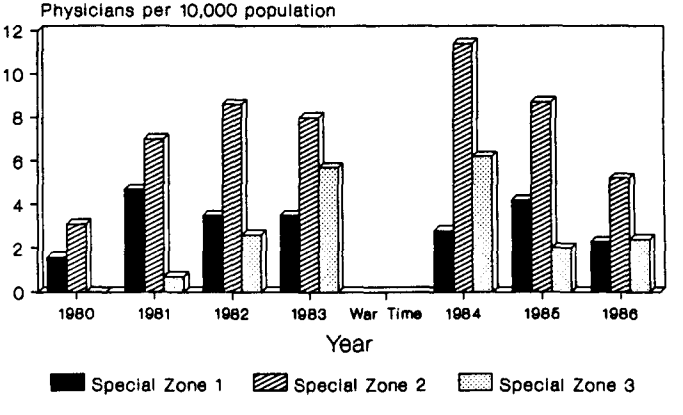
REGION						ZONE		
I	II	III	IV	V	VI	1	2	3
ESTELÍ NVA. SEGOVIA MADRIZ	LEÓN CHINANDEGA	MANAGUA	CARAZO GRANADA MASAYA RIVAS	CHONTALES BOACO ZELAYA CENTRAL	MATAGALPA JINOTEGA	ZELAYA NORTE	ZELAYA SUR	RÍO SAN JUAN

Table 1. Physicians by Region
Nicaragua 1980-1983 1984-1986



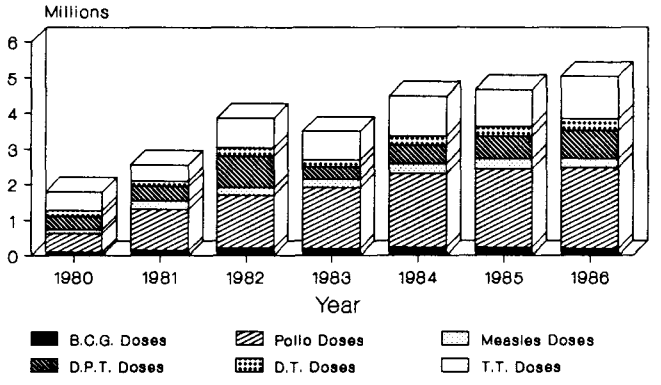
Source: Anuario Estadistico DINEI-MINSA

Table 2. Physicians by Special Zone
Nicaragua 1980 - 1986



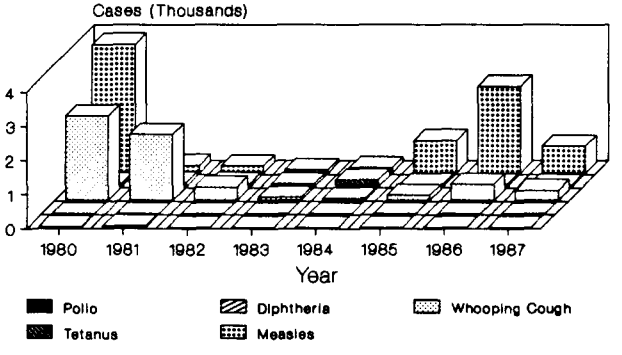
Source: Anuario Estadistico
Atencion Medica

Table 3. DOSES OF VACCINES ADMINISTERED
Nicaragua 1980-1986
1980-83 (Peace Time) 1984-86 (War Time)



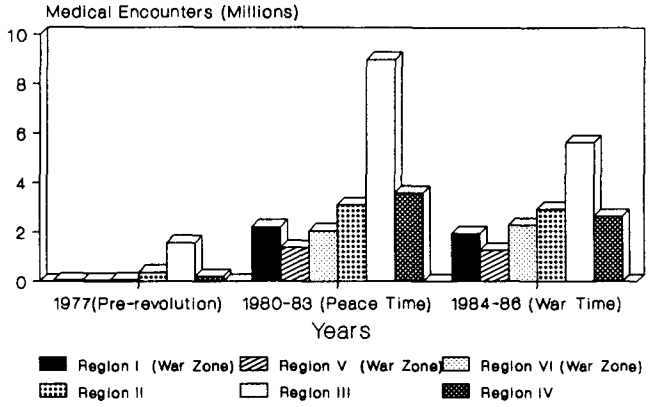
Source: Anuarios Estadisticos 1980-86

Table 4. Transmittable Diseases Reported
Nicaragua 1980 - 1987
1980-83 (Peace Time) 1984-87 (War Time)



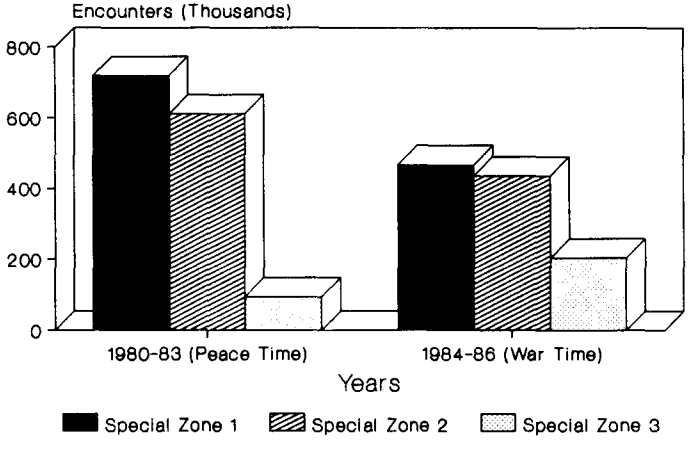
Source: Series Cronologicos 1980 - 1987
DINEI-MINSA

Table 5. Encounters by Regions/War Zones
Nicaragua 1977 1980-1983 1984-1986



Source: Anuario Estadistico DINEI-MINSA

Table 6. Encounters by Special Zone
Nicaragua 1980-1983 1984-1986



Source: Anuario Estadistico DINEI-MINSA

Table 7

UNICEF - NICARAGUA
Financial Assistance for Projects (in US $)

	Project	Amount Expended in Year(s) 1979 - 1983 [a]	1988 [b]	Program Duration
1.	Prevention and Control of Diarrhea	400,000		(1979-1983)
2.	Immunizations	421,500		(1979-1983)
3.	Breastfeeding	100,000		(1979-1983)
4.	Child Disabilities	342,000		(1979-1983)
5.	Primary Health Care	1,600,000		(1979-1983)
6.	Rural Health Services for Children	75,000		(1979-1983)
7.	Pre-school Services	224,000		(1979-1983)
8.	Basic Popular Education	200,000		(1979-1983)
9.	Water Supply	180,000	120,600	(1979-1986)
10.	Sanitation in Rural Areas	151,000		(1979-1983)
11.	Nutrition Project	280,000		(1979-1983)
12.	Popular Education	74,000		(1979-1983)
13.	Urban Development	803,000		(1979-1983)
Total		$4,851,000		

Sources:
a UNICEF 1983 UNICEF Program: Nicaragua. Managua, Nicaragua. mimeo.
b UNICEF 1988 La Cooperacion de UNICEF en Nicaragua. Documento preparado para: Mid-Term Review. Managua, Mayo 23-25, 1988. mimeo.

Table 8

UNICEF - NICARAGUA
Financial Assistance for Projects (in US $)

	Project	Amount Expended in Year(s) 1979 - 1983 [a]	1988 [b]	Program Duration
14.	Five Year Plan for Rural Development (PQRDI)		685,300	(1986-1990)
15.	Five Year Plan for Child Survival (PQSI)		1,383,100	(1986-1990)
16.	Five Year Plan for Food and Nutrition (PQAN)		1,722,100	(1985-1989)
17.	Universal Primary Education and Literacy (UPEL)		91,500	(1983-1988)
18.	Handicapped Children and Early Stimulation		75,500	(1981-1988)
19.	Pre-School Non-Formal Education		18,300	(1986-1988)
20.	Women in Development		140,300	(1986-1988)
21.	Basic Services in Ciudad Sandino		n/a	(1987-1991)
22.	Urban Basic Services		n/a	(1987-1988)
23.	War Refugee Project		441,700	(1987-1988)
24.	Women's Credit Project		240,000	(1985-1989)
25.	Children and Adolescents at Risk		150,000	(1987-1988)
26.	National Production of the ORT Salts		66,700	(1988)
27.	Infant Nutrition in Urban Areas		36,000	(1986-1988)
Total		$4,851,000	$5,171,100	

Sources:
a UNICEF 1983 UNICEF Program: Nicaragua. Managua, Nicaragua. mimeo.
b UNICEF 1988 La Cooperacion de UNICEF en Nicaragua. Documento preparado para: Mid-Term Review. Managua, Mayo 23-25, 1988. mimeo.

Second, the quality of health services was recognized as deficient. This was due in part to the fact that an increasing number of medical personnel were recent graduates and had little experience in the delivery system.

Third, the supply of services was recognized as insufficient in relation to demand and needs. Since 1984 utilization measures, such as medical encounters, seemed to suggest that the supply of services was at best only being maintained and was actually decreasing in Region III (Managua) and on the Atlantic coast (tables 5 and 6). More problematical still was the fact that the system was not adjusting to shifts in population growth, age structure, and movement. There continued to be an exaggerated reliance on hospital services by adults when children continued to have the most need. For example, there were fewer pediatric encounters in 1986-1987 than in the period 1984-1985 even though a declining infant mortality and a high fertility rate increased the absolute number of children needing care.

International Organizations and Health in Nicaragua

The discussion now turns to the role, positive and negative, played by international organizations in health delivery in Nicaragua. Reference has already been made to the recognition that the international health organizations gave to Nicaragua for its efforts in primary health care during the period 1979-1984. We now turn to a discussion of the more detailed involvement of the World Health Organization, its regional affiliate, the Pan American Health Organization (PAHO), and UNICEF. The discussion would be incomplete, however, without an analysis of the role played by two American governmental agencies, the United States Agency for International Development (USAID) and the Central Intelligence Agency (CIA). In fact, the policies of those two institutions have, at different times and in different ways, shaped the evolution of the Nicaraguan national health system and even the funding priorities of the international health donor agencies. We will begin with a brief overview of their respective roles.

The Epidemiology of War

United States health assistance to the Somoza government was minimal until the mid-1960s, when a loan of $2.2 million provided for fifty-five rural health centers. In 1973 the underutilization and inefficiency of the rural health center program prompted

USAID to propose two grants, one to enhance community use of the centers, and the other to improve planning and administration of the rural health programs. In 1977 a third program was funded whose purpose was to provide potable water and sewerage systems to rural communities. Somoza used the two programs as part of his counterinsurgency and pacification programs in Esteli and Matagalpa (Donahue 1986:18).

In 1976 American health advisors and high ranking officials of the Somoza Ministry of Health met in Chinandega to discuss among other issues how the duplication and fragmentation of the existing health sector might be addressed. Both parties agreed that the answer lay in the "promulgation of a new organic law for the health sector, establishing a single institution combining the functions of the major existing health agents" (USAID 1976:239). The integration did not take place under Somoza; it was finally realized in the creation of the Unified National Health System (SNUS) on August 8, 1979, three weeks after the revolution. USAID funding also went to the construction of a new office complex in Managua for the Ministry of Health and to the construction of several hospitals. This funding, already in the pipeline at the time of the revolution, did not cease until March 1982 when the Reagan administration ended bilateral assistance to Nicaragua. Under pressure from the United States, the World Bank (IBRD) ended lending to Nicaragua in June of the same year and the Interamerican Development Bank (BID) followed suit in February 1984. Congress would not again propose any foreign aid to Nicaragua until March 1988.

The end of bilateral assistance to Nicaragua was part of a larger policy of military, economic, and political destabilization initiated by the Reagan administration in November 1981 with the signing of National Security Directive No. 17. The CIA was allocated $19.5 million and authorized to organize anti-Sandinista units of the former Somoza National Guard for military operations in Nicaragua. By June 1982 the so-called contras were assassinating minor governmental officials, and were carrying out attacks against agricultural cooperatives and health clinics, primarily in the central and eastern parts of the country (Regions I, V, and VI and Special Zones 1, 2, and 3). Between 1983 and 1984 the CIA and its operatives, "unilaterally controlled latino assets" (UCLAs), would carry out twenty-two air, land, and sea operations against Nicaragua (Kornbulh 1987:29). The revelations of these activities in April 1984 led to a congressional cutoff of aid to the contras later that year. In the meantime, the Reagan administration initiated a trade embargo against Nicaragua and shifted the coordination

of covert operations to the National Security Council. In June 1985 Congress authorized $27 million in "humanitarian" aid to the contras and one year later provided $100 million in military assistance.

In August 1987 the presidents of Central America signed the Peace Plan in Guatemala. In March 1988 the Sandinistas and the contras agreed to a cease-fire. In the same month Congress rejected further military aid to the contras, but approved $47.9 million in aid. Of that amount $17.7 million was allocated to the contras, $10 million for a commission to monitor compliance with the cease-fire agreement, and $2.5 million to USAID to administer a grant of $17.7 million for medical care and other services to children who are victims of the war (*New York Times*, April 6, 1988). The legislation directed that "none of the assistance may be provided to or through the Government of Nicaragua" ("Children's Survival Assistance Program" - Public Law 100-276).[2]

USAID contracted CARE International to carry out a needs assessment and feasibility study. CARE made its recommendations in a report dated June 17, 1988. The report lists among the key service providers two governmental agencies, five multinational organizations, three bilateral aid programs, and some twenty-six private voluntary organizations (PVOs).[3]

The CARE needs assessment team estimated that the number of children under 17 years of age affected by the war exceeded 500,000. These included children living within the conflict zones, especially Region V (Chontales), Region VI (Matagalpa), and Region I (Esteli); children returning to Nicaragua as war refugees, especially along the Atlantic coast; children displaced by war and living in marginal urban areas; and those with direct needs as a result of the war, including the orphaned, the physically injured, and the psychologically traumatized.

CARE noted that the immediate needs of children "are offset, to a degree, by the tenacity of the governmental ministries and other service providers in maintaining basic levels of outreach coverage, even within the war zones" (1988:4). (See tables 1, 5, and 6.) Nevertheless, shortfalls in basic food production in the war zones contributed to deteriorating nutrition, while a galloping inflation rate made the purchase of even the most elemental cash goods prohibitive for both families and for governmental programs dependent on foreign exchange.

The impact of the war on the Nicaraguan people can be measured in the short and long term. The loss of life has had an immediate and personal effect on many

Nicaraguan families. Since 1981 some 50,000 lives have been lost in the conflict. When combined with the 40,000 who died during the insurrection of 1979, nearly .04 percent of the country's 3.4 million people have died during the past ten years. That is a proportionately greater aggregate death rate than the .003 percent experienced by the U.S. population during the Vietnam War (1965 to 1973) or the .03 percent experienced during World War II (Garfield et al. 1987:615; CARE 1988:8).

Given the youthfulness of the population, it is not surprising that the war has taken a high toll on children. By 1987 the number of orphans had reached 10,077; those wounded, 3,407; child amputees, 600; burn victims, 200; children with spinal cord injuries, 200; kidnapped, 2,236; and killed, 1,553 (CARE 1988:7,47). CARE found that many injured or orphaned children were already being cared for within their communities. Many of the children who received specialized care for burns and amputations were confined to their homes for lack of ongoing referral and treatment services (CARE 1988:7). Among the orphaned children, only 531 were institutionalized, the majority being cared for in the homes of friends or relatives. Recent Nicaraguan legislation provides a pension of 25 percent of the deceased parent's monthly income for each child orphaned by the war (CARE 1988:65). The long-term effects of the war will be felt in the continuing need for secondary and tertiary care services for the handicapped. More difficult to assess is the effect of the psychological trauma on both children and adults.

A recent study (Myers 1987) compared two communities, one in a war zone near the Honduran border and one in a conflict-free zone near the border with Costa Rica. The war zone community suffered greater losses in agricultural production than did the control community. Both evidenced declines in the consumption of basic staple foods, but considerable differences existed in the percentage of decline between the two communities. For example, 67 percent of the households in the war zone village consumed less corn as compared with 37 percent in the other; for rice it was 78 percent and 58 percent less and for beans 61 percent and 35 percent less. The researchers found low prevalence of severe acute undernutrition in both towns, which they suggest may be due to the government rationing system that insures minimal supplies of staple commodities.

Among the children sampled in the two towns (n=108), only 38 percent in the war zone community had all vaccinations complete, as compared with 78 percent in the non–war zone community. Of the twenty community health workers serving in the

rural areas around the war zone community, ten had been kidnapped, and five had resigned due to threats from the contras. The auxiliary nurse in the local health post had been killed.

Significant differences in degree of anxiety and depression were found among people in the two towns, as measured on the Hopkins Symptom Checklist-25 (HSCL), but in the direction opposite of that expected. Among female heads of household in the non–war zone community, 74.4 percent were classified as having significant emotional stress, as compared with 54 percent in the war zone community. Percentages of school-age children reporting nightmares was also higher in the non–war zone community (60 percent as compared with 36 percent in the war zone community) (Myers 1987:11). One explanation for the unexpected difference is that the people from the war zone community are repressing their emotional stress in their daily struggle to survive. People farther from the conflict may give freer expression to their anxieties (Myers, personal communication).

Another explanation may be found in the nature of the Nicaraguan struggle itself. "National revolutions, despite the high social costs they entail, have always meant, for the people who are their own protagonists, the gradual regaining of a collective identity and the forging of their own historic project . . . You can't separate psychology from politics, from the way human beings are shaped by a particular historic moment . . . The high level of popular participation, the presence of international solidarity, the consciousness of participating in a historic process are themselves powerful and effective resources, which compensate in part for the material resources that are lacking" (attributed to Dr. Manuel Madriz in *Instituto Historico Centroamericano* 1987:17-19).

The self-conscious intensity of the struggle among people in the war zone community may itself account for the lower prevalence of emotional distress. If such is the case, then one of the manifest intentions of the United States' policy of low-intensity conflict (LIC), to generate civilian discontent may have the opposite effect among a population that sees itself as exercising independence and autonomy in the face of direct aggression. If adults have more mental resources with which to handle the emotional trauma caused by war, children have fewer resources and so are especially vulnerable to psychological stress. CARE noted the difficulty of measuring the extent and degree of psychological trauma due to the war. They estimate that there may be 40,000 to 50,000 cases just among children, given the fact that some 400,000

children live in the active conflict zones and that another 250,000 have been displaced as their families fled the fighting (CARE 1988:11,14).

The Epidemiology of Survival

This historical overview of the evolution of the Nicaraguan political economy, especially in war time, provides the context in which to analyze and evaluate the programs of the international health organizations, planned and carried out with the Nicaraguan government ministries. At issue is the extent to which the international health organizations in Nicaragua place primary health care programs in a broader context of coordination with social, economic, and political development. The alternatives to comprehensive primary care are, as Rifkin and Walt suggest, the more narrowly focused "selective primary health care" programs, such as child immunization, oral rehydration therapy, and growth monitoring (1986:563). Selective programs are more easily controlled by medical professionals, demand no community planning, only minimal local organization, and no change in the existing economic or power relations in the society. As such, health is seen primarily as a disease problem, not a development problem (1986:562). In the case of Nicaragua, the evidence suggests that international health organizations early on attempted to place primary health care efforts within a development framework. Later, as the effects of military and economic destabilization overtook development efforts, the international health organizations turned to the support of survival programs.

UNICEF

Table 7 illustrates the kinds of programs and levels of funding provided by UNICEF during the first period of health reorganization and expansion in Nicaragua. While the funding of "selective primary care programs" is present, we note that the largest percentage of funding went to primary health care. This included an intensive joint effort with the WHO and the MINSA to train several different types of volunteer health promoters with specializations in sanitation, community health, mother-child care, school health, occupational health, clinical care, and midwifery. Other health-related programs included water supply and sanitation in rural areas. UNICEF provided funds to the Ministries of Education, Agriculture and Agrarian Reform, and

the Social Security Institute (INSSBI) for several projects aimed at improving services for disabled children, basic education, rural vocational education, pre-school services, urban development, and nutritional improvements. These latter programs were at first uncoordinated, which led to an effort beginning in 1984 and continuing in 1985 to integrate the activities of the several governmental sectors receiving UNICEF funding. These efforts were consolidated between 1986 and 1988, leading to intersectoral cooperation and the integration of basic services provided by various ministries (UNICEF 1988:2).

During the period 1984-1985, faced with increasing contra activity and deteriorating economic conditions, the MINSA sought to consolidate its health efforts. In part to offset its forced reallocation of resources to the secondary and tertiary levels of care, the MINSA agreed to participate in the "Child Survival" program that UNICEF was promoting throughout Central America. In Nicaragua the Child Survival Program brought together and coordinated the activities of the Ministries of Health, of Education, and of Social Welfare, as well as of the Faculty of Medicine (UNICEF 1988:3).

At the same time UNICEF, WHO/PAHO, and the Nicaraguan government (GON) initiated the Five Year Plan for Food and Nutrition (PQAN). The plan sought to reinforce primary health care efforts among women and children, as well as move toward a future national plan that would elaborate food policies designed to decrease the possibilities of malnutrition (UNICEF 1988:4).

By 1986 the deteriorating conditions in the war zone (Regions I,V, and VI) prompted UNICEF and the GON to formulate a Five Year Plan for Integrated Rural Development (PQDRI) in which the basic services for children in education, health, and welfare would be integrated. The infant mortality rate in the Central Region of the country was 130/1000, double that of the national average. The war, besides the casualties, also produced major interruptions in the peasant agricultural economy in the Central Region. The result has been abandonment of the rural countryside, resettlement of peasants into cooperatives and state farms, or migration to the cities, all accompanied by a widespread decline in agricultural production and an increase in malnutrition. For that reason UNICEF and the GON elected to bring the Child Survival Program and the Feeding and Nutrition Program, both national programs, under the general umbrella of the Rural Development Plan in the Central Region. In each program UNICEF has been an advocate within the GON for intersectoral

coordination, as well as community participation in the planning and delivery of services (UNICEF 1988:5).

The activities of UNICEF undertaken since 1984, detailed in table 8, clearly reflect the needs generated by the war, especially, but not exclusively, in the Central Region of the country. The deteriorating nutritional levels of children, increasing cases of transmittable diseases, particularly measles, and growing numbers of war refugees, all characteristic of this period, continue to the present. As a consequence, by 1988 three-quarters of UNICEF's funding was targeted to rural development in the war zone, child health care, and feeding and nutrition programs. The other programs undertaken since 1984 and listed in table 8 have been themselves integrated into the Rural Development Plan (PQDRI).

Between 1986 and 1988, UNICEF continued to cooperate with the MINSA to integrate health programs with the development efforts of the several ministerial bureaucracies of the GON working in the conflicted Central Region of the country. In the process it became evident that the national/regional/health area structure of the National Health System (SNUS) and the general administration of the MINSA did not lend themselves readily to the Rural Development Plan under way in the Central Region. The health region/clinic area structure had grown out of the early attempt to redistribute health resources more equitably throughout the country. The intent of the regional/area structure was standardization of the size and distribution of the population to be served. Health sector boundaries were bureaucratically drawn to conform to what seemed to be the most rational distribution of resources for a given population. The medical referral system linking health post to area clinic to regional hospital likewise reflected the planners' model. While the region/clinic area structure achieved numerical homogeneity, it did not correspond to internal social, economic, and hygienic diversity. "Geographical boundaries were created that did not correspond to the tradition or reality, lived and felt by the local inhabitants" (OPS-Nicaragua 1988:23).

The war gradually exacerbated the differences between model and reality already present in the delivery structure. The war gradually created population shifts and changed morbidity patterns both in the war zones as well as in the areas to which refugees fled. The centralized planning and delivery activities of the MINSA at both national and regional headquarters did not allow adequate response to population shifts and to changing health needs at the local level. As a result, certain health facilities

were underutilized while others were overwhelmed. Allocation of medicines and supplies suffered the same disequilibrium. The result was local outbreaks of disease, such as the measles epidemic in 1986 in Region VI. Finally, the SNUS, never well coordinated with the health efforts of the armed forces, the private sector, or with the health activities of other ministries, often duplicated services at the local level.

In its Health Plan 1988-1990, the MINSA proposed the implementation of "The Territorial Health System" ("Los Sistemas Territoriales de Salud" STS) (MINSA 1988b:190-196). The intent was to retain the same criteria of equity found in the original regional/area structure. The organizational focus, however, would no longer be the area clinic or regional hospital, but the local community comprising homes, schools, day-care centers, factories and workshops, and whatever community organizations exist in a given territory, neighborhood (*barrio*) or rural district (*reparto*) (OPS-Nicaragua 1988:18). WHO/PAHO became the major facilitator of this reorganizational effort.

WHO/PAHO

Between 1980 and 1982, the World Health Organization and its regional affiliate, the Pan American Health Organization, provided over $9 million to health programs in Nicaragua. An additional $5 million was added to that amount between 1983 and 1985 (interview with Dr. Miguel Marquez, representative of the WHO/PAHO in Managua, in *Barricada*, July 13, 1983, p. 14). In March 1982, WHO, PAHO, and UNICEF entered into a dialogue with the Ministries of Health and of Planning on primary health care strategies for Nicaragua (MIPLAN/MINSA 1981:7; MINSA n.d.). The discussions led to the presentation in April 1982 of the Comprehensive Plan for Assistance to Health Areas (PIAAS) by the Division of Primary Health Care (MINSA 1982). The purpose of the plan was to provide the area clinic directors with a uniform planning, organizational, and reporting tool. Other major areas of WHO/PAHO support were in the provision of vaccines and the cold chain during the mass drug administration programs, called Popular Health Days. In 1982, WHO/PAHO officially recognized Nicaragua's early successes in primary health care, and in 1983 Leo Guido, then Minister of Health, was named president of the executive committee of PAHO.

During the Second Period (1984-1985), WHO/PAHO focused its attention on the support of maternal-child health care programs, and feeding and nutritional programs. Support for these programs continued during the Third Period (1986-1988) (OPS/OMS/ INCAP-PASCAP 1987; OPS 1988; OPS/INCAP 1988). However, in 1988 WHO/PAHO turned its attention to the organizational problems that faced the SNUS as a result of the war, specifically to the proposed reorganization of the Health Regions into a Territorial Health System (STS) (MINSA 1988b:190-196; OPS-Nicaragua 1988). Based upon its own experience (OPS-Washington 1988), PAHO offered three specific objectives for the reorganization. The first was to assure that the health interventions were necessary and able to meet the health needs of the people in that particular place. The second objective was to carry out the reorganization in such a way as to overcome any "top-down" features of the programs and lack of contact between levels of care. Third, there had to be an effort to assure community participation as well as coordination of health efforts among whatever providers, public or private, existed in the locality.

Ten strategies were elaborated to enhance the achievement of the objectives of the Territorial Health System. Health activities are to be integrated with the development efforts carried out by other ministries in fields such as housing, agriculture, and commerce. Decision-making authority must be decentralized and concentrated at the level where the effects of the action are to realized. Planning should be situational and relevant to the needs and opportunities found in the locale. Local health planning will demand the reactivation of Popular Health Councils, but this time at a more local (territorial) level. National ministries must allow the various sectors (education, commerce, transport, housing, water and sewerage, agriculture, and industry) to plan and act with authority at the local level. The STS requires an information base necessary for the decision-making process which reflects local conditions. Local administrative capacity for carrying out local projects should be reinforced. Disease prevention and control programs need to be integrated at the local level. MINSA personnel will need to be trained to administer the actions undertaken in the STS. Finally, research activities must be initiated that would provide the feedback necessary for the STS to adapt to meet changing conditions at the local level (OPS-Nicaragua 1988:25-35).

On August 9, 1989 the first test of the STS was undertaken. On that date, President Daniel Ortega announced the Campaign for the Defense of the Lives of

Children (Frieden 1988:15; MINSA 1988c). The goal of the campaign is to reduce infant and child mortality by 50 percent by concentrating efforts on diarrheal illness, respiratory infections, and neonatal mortality. Strategies include increasing vaccination levels, and medical encounters among children, and redirecting resources to the war-torn Central Region, scene of highest infant and child mortality and increasing malnutrition. The campaign is funded in part by UNICEF as a component of their Five Year Plan for Child Survival (1986-1990). The campaign, however, incorporates several features of the STS Program supported by WHO/PAHO. These features include intersectoral coordination at national, regional, and local levels, as well as active participation at the local level. Symbolic of the intersectoral coordination is the fact that the campaign is not directed by MINSA, but by a presidential commission made up of the Ministries of Health, Education, Transportation, Construction, and Agriculture, as well as the unions and the armed forces. The intersectoral structure is repeated at regional and local levels where MINSA, local municipal governments, and popular organizations are also involved. At the local level health workers are provided with discount bus fares. Road construction is to focus on inaccessible areas with high infant mortality. More hygiene will be taught in the schools and priority construction will be given to schools that lack water or sewerage. The army has begun to provide janitorial and waste management services to hospitals and health centers. Agricultural cooperatives are allocating milk for pregnant women and children. Unions and the Ministry of Agriculture are providing basic food baskets to pregnant women and women with young children (Frieden 1988:15). The campaign represents a mix of vertical and horizontal health strategies in a coordinated development program.

While the success of the WHO/PAHO projects in support of the STS and child survival can only be judged at a later date, the nature of the projects and the decision to support them is what is of relevance to the argument in this paper.

Conclusion

The questions raised at the beginning of this paper had to do with the allegations of critics who argue that international health organizations play a politically conservative role in Third World nations. Our discussion has focused upon the case of Nicaragua. We can now make some comparisons and offer some conclusions.

Ugalde (1985:48-49) correctly places the promotion of primary health care through organized community participation in the larger context of political theory. Dodson and O'Shaughnessy (1985:123-124) take a similar approach in their analysis of the role of base Christian communities in the democratization of Nicaraguan society. Both see these organizations as expressions of popular as opposed to liberal democracy. When organized into health committees, into neighborhood churches, or into agricultural cooperatives, people are participating in a democratic process as legitimate as, but different from, that characterized by political parties, elections, and representative government. One might even argue that electoral politics is a necessary, but not sufficient, condition for a genuine democracy to exist. Electoral democracy without grass-roots organization, local decision-making and accountability does not guarantee either equity or protection of human rights.

Ugalde goes on to argue that the promotion of health committees by international organizations as "forums to express the demands or to request assistance when it is needed" is, in his words, "wishful thinking" (OPS\Washington 1978:14 quoted in Ugalde 1985:48). In fact, Ugalde concludes that such symbolic participation may legitimate status quo regimes by producing compliant leaders after destroying popular, democratic ones (1985:49). In his mind, such decision-making, planning, and management are political functions and not actions properly taken by voluntary associations of citizens.

Yet, I would argue in the case of Nicaragua, that international health organizations share a common purpose with local health committees. Both have significant roles to play in the formation and consolidation of the Nicaraguan state. Both act as catalysts of change, from above and below, in the process of nation building. Once Somoza's "liberal democracy" was overthrown, citizen involvement in the political process in Nicaragua found expression in the literacy crusade, popular health days, neighborhood defense committees, and agrarian cooperativism. The Sandinistas institutionalized the Popular Health Councils at local, regional, and national levels to offset the bureaucratic dominance of medical professionals within the MINSA (Donahue 1986:95). Initial funds from UNICEF went to the training of primary health care workers to work within the broadly defined development goals of the government. When it became clear that the Nicaraguan government lacked an integration of services provided by several ministries, international organizations again assisted in that effort.

As the war strained the resources of the government to meet the needs of people in the central and eastern regions of the country, international organizations, such as PAHO and UNICEF, supported government child survival and nutrition programs, but as part of an integrated development effort among the several state agencies in each region. The most recent example of how international organizations can assist in the consolidation of the state is the Territorial Health Systems (STS). This effort is, in reality, a redefinition of the boundaries of political decision-making. The outcome may be a more appropriate legal and juridical framework in which to address development and survival issues at the most local level. For the first time in Nicaragua local organizations of citizens will have the legal authority to participate in planning and in fiscal decision-making affecting development efforts in their communities.

International health organizations have played a significant role in the integration and consolidation of the Nicaraguan state apparatus, first in the health sector and then gradually among several sectors. These efforts have been successful, in spite of a war of economic and military destabilization, because of the tenacity of the political leadership and the broad participatory base of the revolution. In sum, Nicaragua is an arena in which international organizations are in a struggle to build up or tear down a young state. The survival, to date, of the revolutionary Nicaraguan state is the result of the convergence of international support and broadly popular national agendas.

Notes

1. For purposes of comparison I have divided the postrevolutionary history into two periods, "Peace Time" (1980-1983) and "War Time" (1984-1987). In reality, the war's impact was felt in some areas much earlier (Garfield 1985). By 1984, however, the effects of the war can be seen clearly in Region I (Esteli), Region V (Chontales and Boaco), Region VI (Matagalpa and Jinotega), as well as in the Special Zones on the Atlantic coast (see map).

2. The CARE report pointed to a "fundamental contradiction in the legislation" between the congressional restriction placed on working through Nicaraguan governmental institutions and the fact that most of the nongovernmental aid organizations do in fact work closely with the government. The report also warned that short-term interventions by NGOs would not provide for continuity of care, implying that only governmental institutions could effectively do so in the long run.

In mid-September 1988 the government of Nicaragua refused the congressional aid. President Ortega commented, "Although in dire economic need and suffering many problems, we Nicaraguans cannot accept from the Yankee Congress this bloodstained money as long as that Congress continues debating the allocation of more funds against the Nicaraguan people" (*Washington Post*, September 21, 1988, p. A28).

3. CARE (1988:48) provided a list of Key Service Providers in Nicaragua which serves as the basis for the following enumeration.

A. Government Organizations: The Government Ministry of Health (MINSA); The Ministry of Social Services (INSSBI); The Ministry of Education.

B. Multilateral Institutions: United National High Commission for Refugees (UNHCR); The International Committee of the Red Cross (ICRC); Pan American Health Organization (PAHO/WHO); The World Food Program (WFP).

C. Private Voluntary Organizations: American Friends Service Committee, USA; Association for the Development of Villages; CANSAVE; CARE; CARITAS; the Evangelical Development Center (CEPAD); Christo Rey; The Catholic Institute of International Relations (CIIR); Church of the Brethren; The Franciscan Fathers; GVC (an Italian organization that cooperates with OXFAM); HAP-NICA (agricultural development project); IBSIM (a Moravian development organization); Juan XXIII; MADRES; The Maryknoll Fathers and Brothers; The Maryknoll Sisters; Medecins de Monde; Medecins Sans Frontieres; National Association of the Partners of the Americas (NAPA); Nicaraguan Red Cross; Nicaraguan Wheelchair Repair Project; NOVIB (a Dutch organization that cooperates with OXFAM); PRONICA; OXFAM Beligique; OXFAM United States; Quixote Center; Redd Barna-

Norway; Save the Children Federation, USA; Unitarian Universalist Service Committee; United States–Nicaragua Sister Cities Program; Witness for Peace.

D. Bilateral Assistance Organizations: Dutch, Norwegian, Spanish.

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